

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8015453			
											REG. NO.				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)				LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			Bertha Jemima BAREMORE							June 11, 1980			7:20 A M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		# UNDER 1 YEAR		# UNDER 24 HRS				
FEMALE		CAUCASIAN		MONTH OCT DAY 19 YEAR 1882			97 YRS.		MONTHS		DAYS		HOURS MIN		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
PA.		US					Calvert								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Prince Frederick		Calvert Memorial Hospital				HOUSEWIFE									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
MD		CALVERTT		LUSBY				ALGONQUIN TRAIL							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
SAMUEL		S.		TITUS		AMMIE		V.		PAUL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		234-03-1135		CARL WILLIS TITUS		BOX 255-C		CORONARY Occlusion							
LUSBY, MARYLAND 20657															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												DUE TO, OR AS A CONSEQUENCE OF Generalized Sclerosis			
												(b)			
												(c)			
DUE TO, OR AS A CONSEQUENCE OF Senility															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
		P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) <input type="checkbox"/> attended the deceased from saw the deceased alive on <u>June 11, 1980</u> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death															
22b. SIGNATURE				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										June 11, 1980			
Roberto de Villarreal		St. Leonard, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE					
CREMATION		6/11/80		METROPOLITAN CREMATORIAL		ALEXANDRIA				VIRGINIA					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
DONALD V. BORGWARDT		PORT REPUBLIC, MD.		JUN 16 1980		Lester Borgwardt									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	0	1	5	4	5	4
												REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR A						
			Dorothy Ann BOWEN						June 6 1980			10:45 M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH AUG 22 1942			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.					
FEMALE		CAUCASIAN					37 YRS			MONTHS DAYS			HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
WASHINGTON D.C.		US					Calvert MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Pr. Frederick		Calvert Memorial			HOUSEWIFE													
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																		
13a. STATE MD.		13b. COUNTY CALVERT		13c. CITY OR TOWN DUNKIRK			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ROUTE 4								
14. FATHER'S NAME FIRST JOHN		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST ELOISE MIDDLE									LAST NEMBY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-38-3598		17. INFORMANT RAYMOND B. BOWEN			ADDRESS BOX 96						ADDRESS LUSBY, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE 1a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1749 Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last																		
18b. DUE TO, OR AS A CONSEQUENCE OF (b)																		
18c. DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 5-27-80 to 6-6-80, that (I) (we) last saw the deceased alive on 6-6-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 6-6-80						
22b. SIGNATURE H. B. BOWEN		22d. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>													
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Emad R. Al-Banna, M.D.		22f. ADDRESS Prince Frederick, Maryland 20678																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 6/9/80		23c. NAME OF CEMETERY OR CREMATORIAL SO MEMORIAL GARDENS			23d. LOCATION CITY OR TOWN DUNKIRK			COUNTY CALVERT			STATE MD.					
24. FUNERAL DIRECTOR NAME DONALD V. BORGWARDT		ADDRESS PORT REPUBLIC, MD.			25a. DATE REC'D. BY REGISTRAR JUN 11 1980			25b. REGISTRAR'S SIGNATURE L. J. McCREARY										
DHMH-16 25M (VRA 15, 4) 1/79																		

0801 1 1980

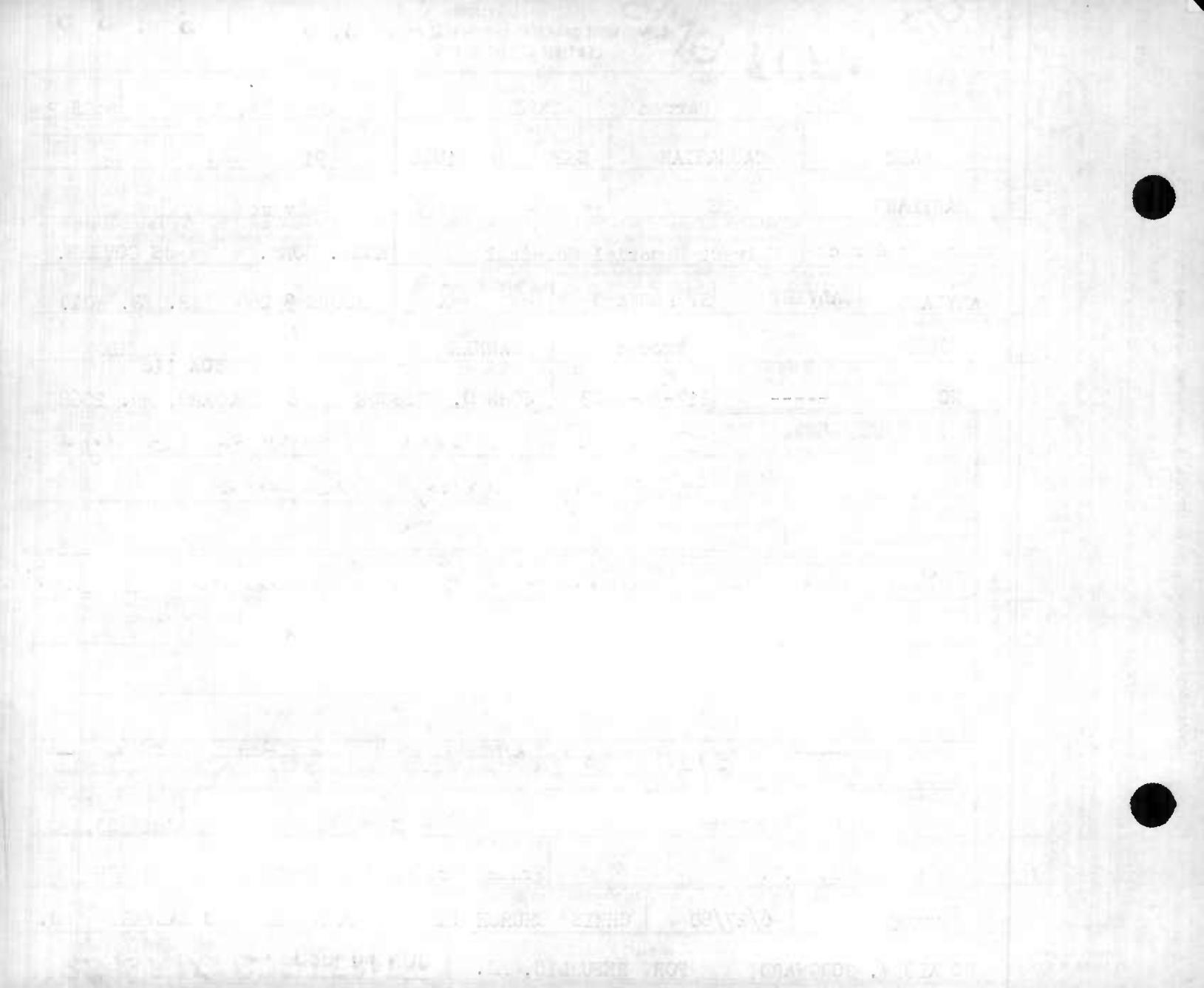
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 15455									
										REG. NO.									
1 - STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR						
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		June 24, 1980			6:25 P.M.						
John Parran BROOME																			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. HOUR							
MALE		CAUCASIAN		MONTH SEPT DAY 4 YEAR 1888				# UNDER 1 YEAR MONTHS 91 YRS				IF UNDER 24 HRS MONTHS DAYS HOURS MIN							
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.							
MARYLAND		US						Calvert											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Prince Frederick		Calvert Memorial Hospital								ASST. COMM.				US GOVERN.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS									
MARYLAND		CALVERT		ST LEONARD		ROUTE # 264				BR. IS. ROAD									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME				LAST									
JOHN				Broome		NANNIE				PETERSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO		17. INFORMANT				ADDRESS				BOX 118							
NO		217-36-6523		JOHN D. BRISCOE				ST LEONARD, MD. 20685											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i>										3 days									
4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery disease</i>																			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>gastroenteritis</i>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
D1 Poss. Aspiration Pneumonia (2) Cerebrovascular Disease (3) gastritis																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (the hospital) attended the deceased from <u>6/24/80</u> to <u>6/24/80</u> , that (I) (was) (was not) last saw the deceased alive on <u>6/24/80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.																			
22b. SIGNATURE <i>A T Munshi</i>										DEGREE									
22c. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar Munshi, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
										22d. DATE SIGNED June 25, 1980									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 6/27/80		23c. NAME OF CEMETERY OR CREMATORIAL CHRIST CHURCH CEM		23d. LOCATION CITY OR TOWN PORT REPUBLIC		COUNTY CALVERT		STATE MD.	
24. FUNERAL DIRECTOR NAME DONALD V. BORGWARDT										25a. DATE REC'D. BY REGISTRAR JUN 30 1980				25b. REGISTRAR'S SIGNATURE <i>Donald V. Borgwardt</i>					
ADDRESS PORT REPUBLIC, MD.																			

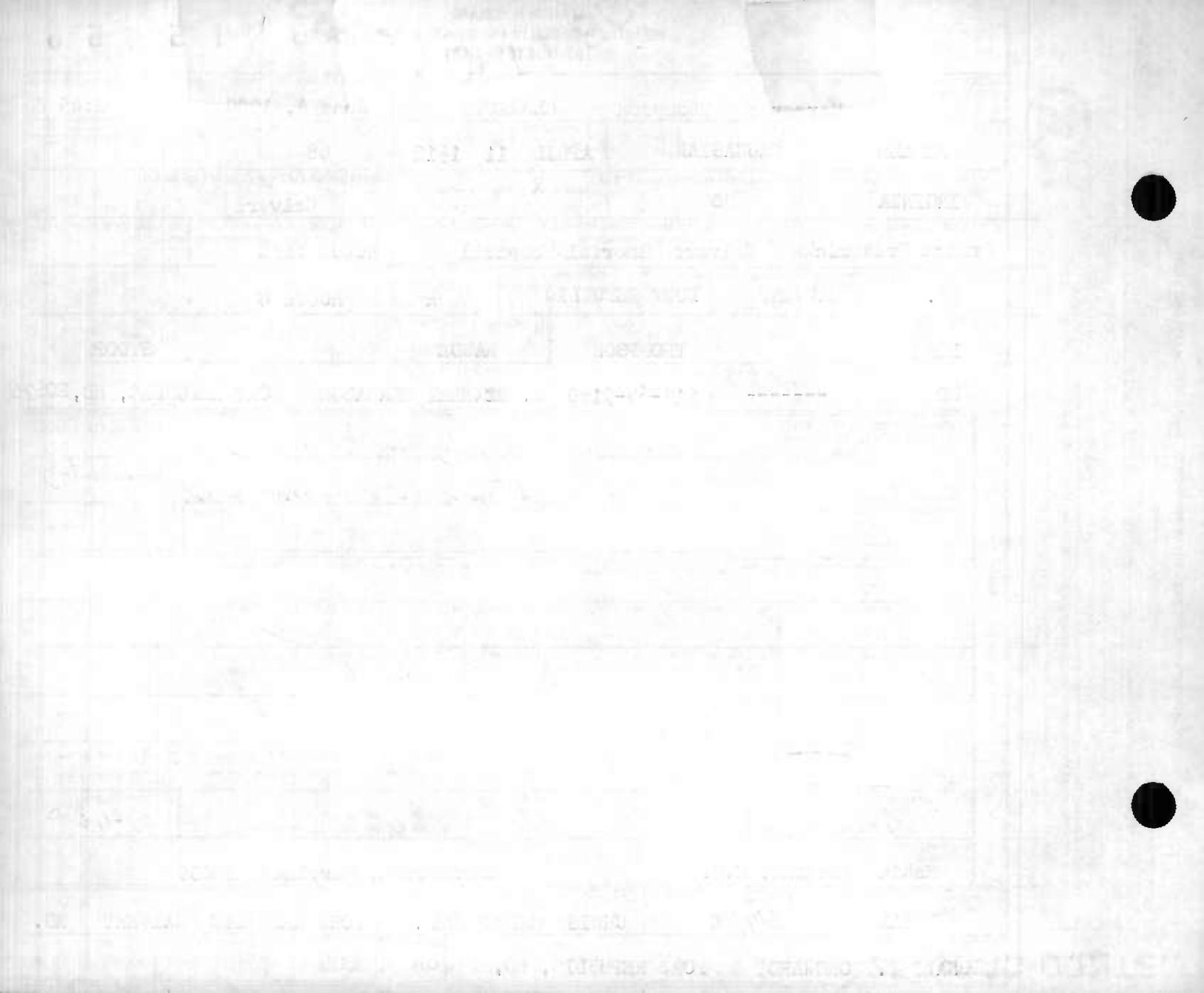


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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-585-5959.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 1 5 4 5 6						
												REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
			Margaret Thompson			CLABAUGH			June 4, 1980			3:45 PM						
3. SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE			CAUCASIAN			APRIL 11 1912			68 YRS			MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH									
VIRGINIA			US						Calvert MD.									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Prince Frederick			Calvert Memorial Hospital			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. STREET ADDRESS									
13a. STATE MD.			13b. COUNTY CALVERT			13c. CITY OR TOWN PORT REPUBLIC			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			ROUTE 4						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. P-----217-64-9160			17 INFORMANT W. STANLEY CLABAUGH			ADDRESS PORT REPUBLIC, MD, 20676			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (1a) 7999 Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediately						
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac arrhythmia or pulmonary embolism																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:45 P.M. 6 4 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Sudden death												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) HOSPITAL			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (1) this physician attended the deceased from <u>1980</u> to <u>6-4</u> <u>1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.																		
22b. SIGNATURE Mahin Yazdani			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 6/4/80									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Mahin Yazdani, M.D.			22f. ADDRESS Huntingtown, Maryland 20639															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 6/7/80			23c. NAME OF CEMETERY OR CREMATORIAL CHRIST CHURCH CEM.			23d. LOCATION CITY OR TOWN PORT REPUBLIC			COUNTY CALVERT		STATE MD.				
24. FUNERAL DIRECTOR NAME DONALD V. BORGWARDT			ADDRESS PORT REPUBLIC, MD.			25a. DATE REC'D. BY REGISTRAR JUN 10 1980			25b. REGISTRAR'S SIGNATURE R. McElroy									





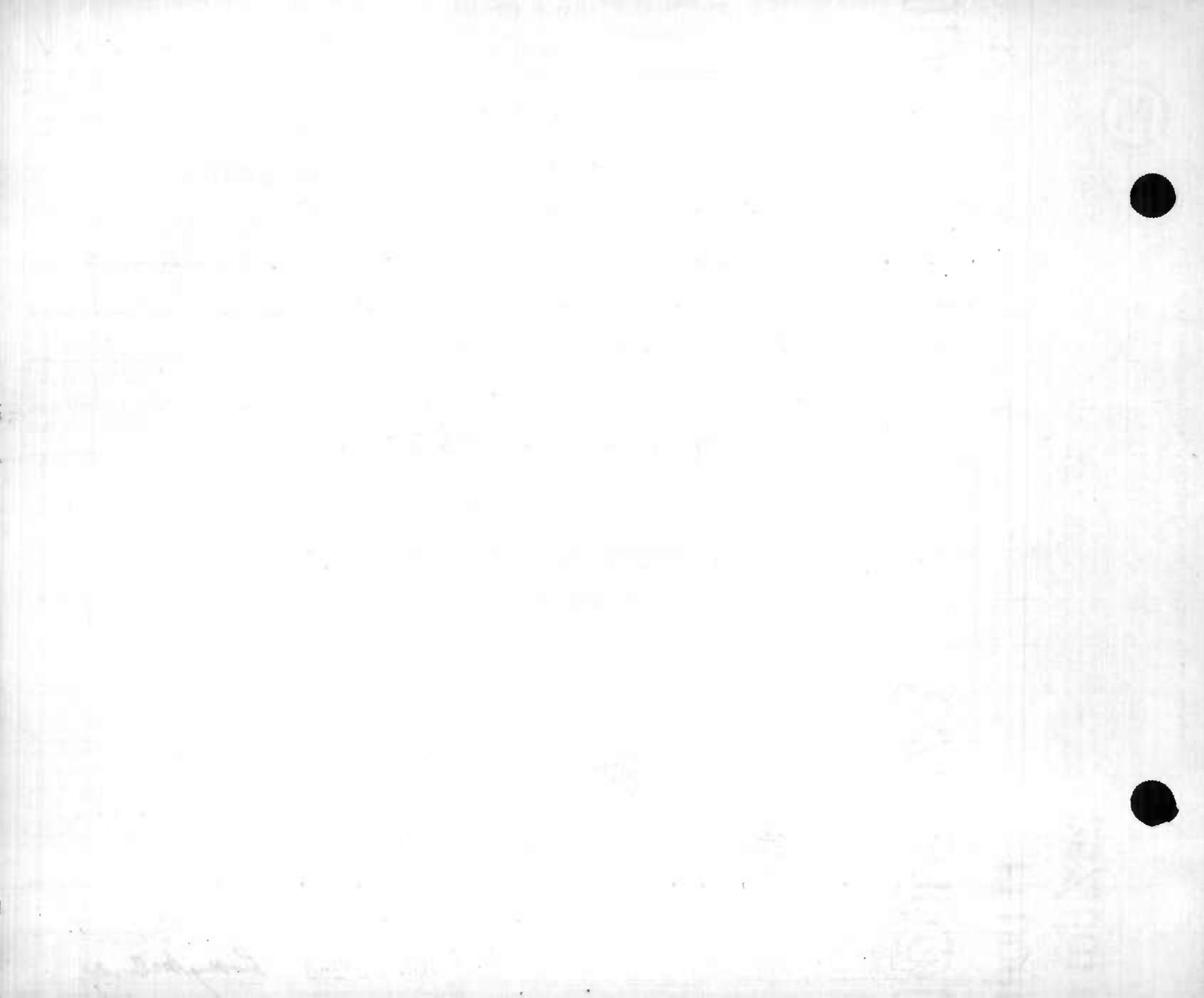
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH80 15457
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Richard			Hal		Coffren	6	21	80	2:45	A		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Male		White		Nov. 30, 1891		88 yrs						
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U.S.A.				Calvert						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Pr. Fred.		Calvert House		Self Employed		Radio Repair						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
D.C.				Washington				3239 Military Road N.W.				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
Julius		E.		Coffren	Martha							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes		W.W.I		579 07 7148 Joyce L. Coffren		6100 Osborne Road Upper Marlboro, Md						
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												
Arteriosclerotic Vascular Disease												
44-09 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 4/4, 1976, to 6/21, 1980, that (I) (we) last saw the deceased alive on 6/20, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did not) view the body after death.												
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				6/21/80						
George J. Weems, M.D.		Huntingtown, Md. 20639										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		23 June 1980		Cedar Hill Cemetery Suitland, Md.		PG Md						
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Robert E. Wilhelm Funeral Home Inc Suitland, Md.				Larry Schenck								
DHMH-16 20M (VRA 15, 4) 7/7B												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please attach to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8015458		
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			Marion DALE CURTIS						June 11, 1980			8:55 P.M.		
3 SEX			4 RACE			5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White			Oct. 10, 1940			39 YRS.			MONTHS DAYS HOURS MIN		
7e BIRTHPLACE COUNTRY			8 STATE OR FOREIGN COUNTRY			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
District of Columbia			U. S. A.									Calvert		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Prince Frederick			Calvert Memorial Hospital			Waitress			Public Restaurants					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a STATE Maryland		13b COUNTY Calvert		13c CITY OR TOWN Huntingtown		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 5830 Carol Court					
14 FATHER'S NAME FIRST Merle			MIDDLE --			15. MOTHER'S MÄDEN NAME FIRST Catherine			MIDDLE --			LAST Goddard		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No						Frank A. Curtis-5830 Carol Court Huntingtown, Md 20639								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY														
IMMEDIATE CAUSE (a) <i>CVA, Brain death</i>														
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Hemorrhage</i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)														
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <u>May 25, 1980</u> to <u>June 11, 1980</u> , that (I) (we) last saw the deceased alive on <u>June 11, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b SIGNATURE <i>R. Yazdani</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED June 12, 1980					
22d PHYSICIAN'S NAME (TYPE OR PRINT) Kiourmarce Yazdani, M.D.			22e ADDRESS Huntingtown, Maryland 20639											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 6/14/80			23c NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d LOCATION CITY OR TOWN Suitland (Pr. Geo's) Md.					
24 FUNERAL DIRECTOR NAME Richard A. Coleman - Upper Marlboro Funeral Home			ADDRESS Maryland 20870			25a DATE REC'D. BY REGISTRAR JUN 13 1980			25b REGISTRAR'S SIGNATURE <i>Holiday McCreedy</i>					
DHMH-16 25M (VRA 15, 4) 1/79														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 1 5 4 5 9						
											REG. NO.							
1 - FOR STATE REGISTRAR			WILLIAM LEMPIS DALRYMPLE			26. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			XXXXXX XXXXXXXX XXXXXXXX XXXXXXXX			6 8 80			4 30 P.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male			White			MONTH DAY YEAR			80			MONTHS		DAYS				
7a. BIRTHPLACE COUNTRY PA.			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH						
US			US			3 - 27 - 1900			CALVERT			Princ. Fred. md						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			13a. INSIDE CITY LIMITS?			12b. KIND OF BUSINESS OR INDUSTRY			13b. STREET ADDRESS						
13a. STATE MD.			13b. COUNTY CALVERT			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13c. STREET ADDRESS ROUTE 4			14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT SUCH FACILITY, GIVE STREET ADDRESS)						
14. FATHER'S NAME FIRST J MIDDLE WILSON LAST DALRYMPLE			15. MOTHER'S MAIDEN NAME FIRST CARRIE MIDDLE LAST SHERIFF			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. WWI 472-07-2681			17. INFORMANT JAMES C. DALRYMPLE			ADDRESS 15711 HUGHES RD. POOLESVILLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Leiomyosarcoma of Hip</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>January 1980</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Occurrence of kidney</i> 1976																		
19a. DATE OF OPERATION 1976			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <i>May 2, 1980</i> to <i>June 8, 1980</i> , that (I) <input type="checkbox"/> lost saw the deceased alive on <i>June 7, 1980</i> and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.																		
22b. SIGNATURE <i>George Jett MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6-8-80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 6/9/80			23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE			23e. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORIAL						
24. FUNERAL DIRECTOR NAME DONALD V. BORGWARDT			ADDRESS PORT REPUBLIC, MD.			25a. DATE REC'D. BY REGISTRAR JUN 13 1980			25b. REGISTRAR'S SIGNATURE <i>George McCreedy</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The 1 retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

15460

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Effrus	MIDDLE M.	LAST FREEMAN	2a. DATE OF DEATH June 5, 1980	MONTH JUN	DAY 5	YEAR 1980	2b. HOUR 1:55 P.M.
3. SEX MALE	4 RACE CAUCASIAN	5 DATE OF BIRTH MONTH MAY	DAY 11	YEAR 1900	6 AGE (IN YEARS LAST BIRTHDAY) 80 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	
7a. BIRTHPLACE COUNTRY ENGLAND	7b. CITIZEN OF WHAT COUNTRY? US	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Calvert							
10. CITY OR TOWN OF DEATH Prince Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DEVELOPER		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE MD.	13b. COUNTY CALVERT	13c. CITY OR TOWN LUSBY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS WHITE SANDS ROAD					
14. FATHER'S NAME MAX HARRIS	MIDDLE	LAST PAT GORNEY	15. MOTHER'S MAIDEN NAME FIRST ROSE		MIDDLE	LAST ALLSCLULEN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. WWI & WWII	16c. INFORMANT VERA M. FREEMAN	17. ADDRESS WHITE SANDS LUSBY, MD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6-8 hrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY</u> <u>ARREST</u>										
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>POSSIBLE ACUTE MYOCARDIAL INFARCTION</u>										
DO TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE <input checked="" type="checkbox"/> CHRONIC RENAL FAILURE										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (We) hospital attended the deceased from <u>5/27/80</u> , to <u>6/5/1980</u> , that (I) (We) last saw the deceased alive on <u>6/5/80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Anwar Munshi</u>	DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED June 5, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar Munshi, M.D.			22e. ADDRESS Prince Frederick, Maryland 20678							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 6/8/80	23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORIAL	23d. LOCATION CITY OR TOWN ALEXANDRIA	23e. COUNTY VIRGINIA		STATE				
24. FUNERAL DIRECTOR DOANED V. BORGWARDT	ADDRESS PORT REPUBLIC, MD.	25a. REC'D. BY DOANED V. BORGWARDT		25b. DATE JUN 11 1980		25c. SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN

TO TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as a burial transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed within 72 hours after the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

RECEIVED
HOSPITAL ENDING PT. SCAN. The law requires that the certificate be executed within 24 hours after death. Page 4 may be
resented by the hospital or attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 1 5 4 6 1

REG. NO.

1. DECEASED NAME [TYPE OR PRINT] Franz NMN HERCHE			2a. DATE OF DEATH MONTH DAY YEAR June 14 1980	2b. HOUR A 10:40 AM
3. SEX <i>male</i>	4. RACE <i>cauc</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>July 4 1916</i>	6. AGE [IN YEARS LAST BIRTHDAY] <i>63</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS.
7a. BIRTHPLACE [STATE OR FOREIGN COUNTRY] <i>Bolivia</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Calvert</i>	
10. CITY OR TOWN OF DEATH <i>Pr. Frederick</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Calvert Memorial</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>carpenter</i>
13a. STATE <i>Md</i>	13b. COUNTY <i>Cal</i>	13c. CITY OR TOWN <i>Huntington</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>Rt #1 Box 130</i>
14. FATHER'S NAME FIRST <i>Martin</i>	MIDDLE <i>Herche</i>	LAST	15. MOTHER'S MÄDEN NAME FIRST <i>Elizabeth</i>	MIDDLE LAST <i>- unk -</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>	16b. SOCIAL SECURITY NO <i>212349615</i>	17. INFORMANT <i>Martilla Herche son of B</i>	ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>4148</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4/17/80</i>	
DUE TO OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction-Ante</i>				
DUE TO OR AS A CONSEQUENCE OF (c) <i>Ch. long. Failure & C.O.P.D.</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <i>5/30 1973</i> , 19 <input type="checkbox"/> to <i>6/4/80</i> , 19 <input type="checkbox"/> , that (I) (we) last saw the deceased alive on <i>5/30 1973</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.				
22b. SIGNATURE <i>Thomas F. Lusby, M.D.</i>			DEGREE	22c. DATE SIGNED <i>6/14/80</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Thomas F. Lusby, M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
23a. FUNERAL CREMATION, REMOVAL <i>Funeral</i>	23b. DATE <i>June 1980</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Miranda</i>	23d. LOCATION CITY OR TOWN <i>Huntington Cal Md</i>	23e. COUNTY STATE
24. FUNERAL DIRECTOR NAME <i>Kawach Funeral Home</i>	ADDRESS <i>Owings Md</i>	25a. DATE REC'D. BY REGISTRAR <i>JUN 20 1980</i>	25b. REGISTRAR'S SIGNATURE <i>John M. Murphy</i>	

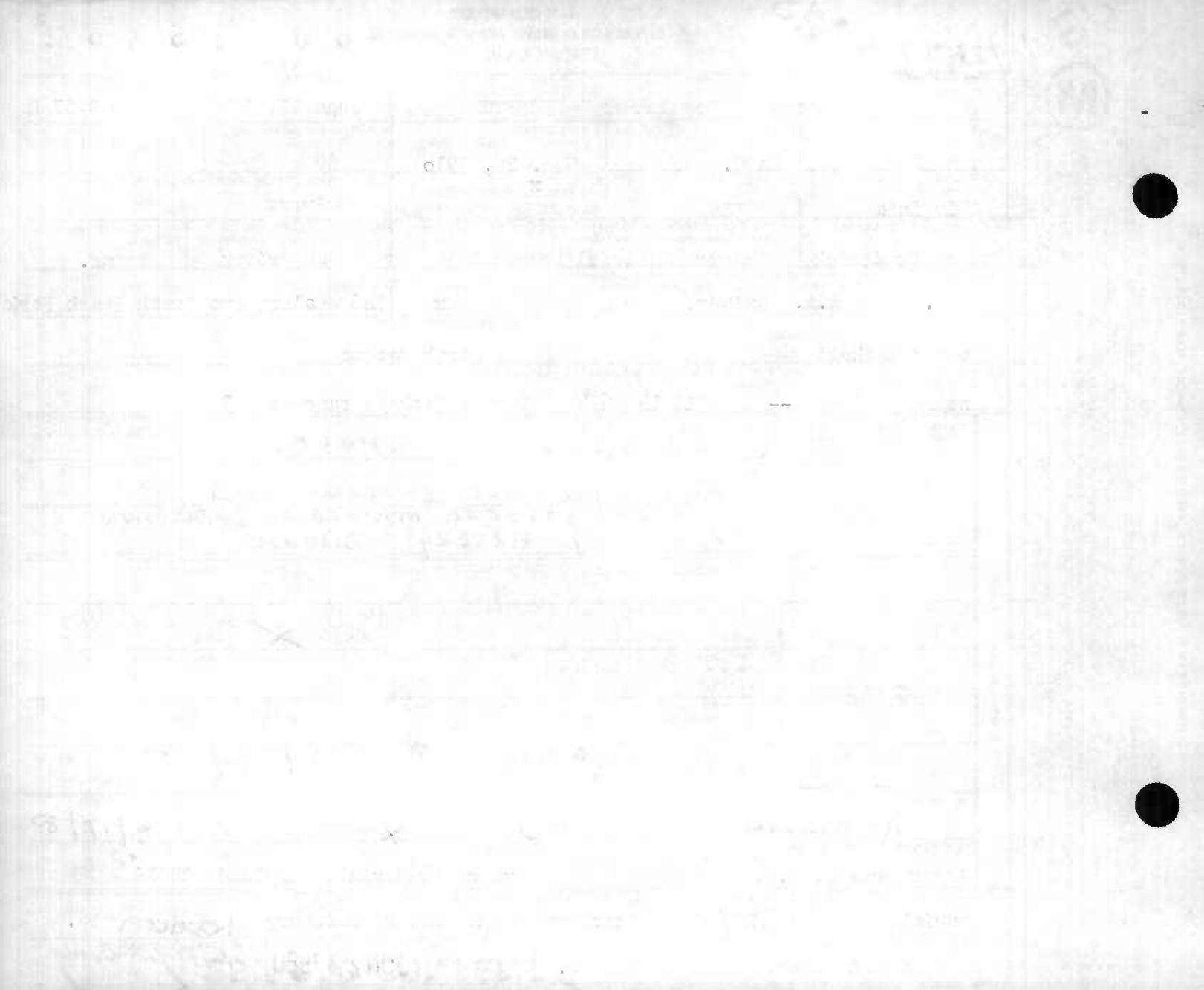
TO HOSPITAL OR ATTENDING PHYSICIAN

DEATH TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed within 72 hours after removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATIONS

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8015462											
										REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR									
Raymond Copeland HESKETT						June 17, 1980						3:57 P.M.									
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
MALE			CAUC.			MONTH DAY YEAR			69			MONTHS	DAYS	HOURS	MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Virginia			USA						Calvert												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Prince Frederick			Calvert Memorial Hospital						Cab driver			trans.									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Md.			Calvert			North Beach			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			746 W. Walnut Ave North Beach Park									
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME																		
FIRST MIDDLE LAST George Heskett			FIRST MIDDLE LAST Sarah Basque																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
no			718 71 9654			Carrie Heskett same as #13															
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK																					
410- DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE EXTENSIVE INFERIOR AND ANTEROLATERAL MYOCARDIAL INFARCTION																					
DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY ARTERY DISEASE																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>6/15/1980</u> to <u>6/17/1980</u> , that (I) (we) last saw the deceased alive on <u>6/17/1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <i>AT Munshi</i>										22c. DEGREE M.D.											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Anwar Munshi, M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial										23b. DATE 6/20/80			23c. NAME OF CEMETERY OR CREMATORIAL Leesburg Union Cemetery			23d. LOCATION CITY OR TOWN Leesburg			23e. COUNTY Loudoun		STATE Va.
24. FUNERAL DIRECTOR NAME Rausch Funeral Home										ADDRESS Owings Md.			25a. DATE REC'D. BY REGISTRAR JUN 23 1980			25b. REGISTRAR'S SIGNATURE <i>John J. Kennedy</i>					



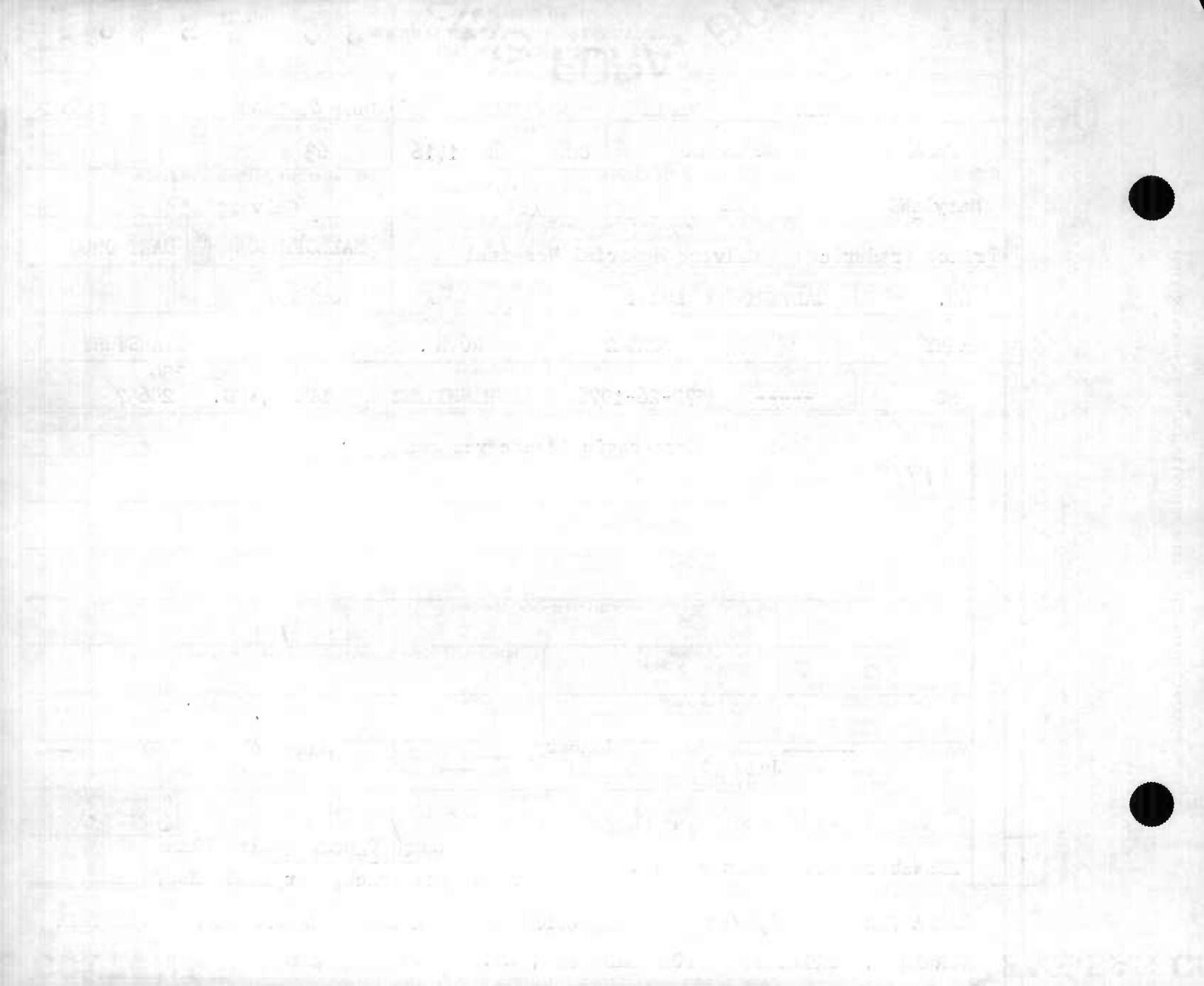
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial or transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 310-355-5911.

MEDICAL CERTIFICATION

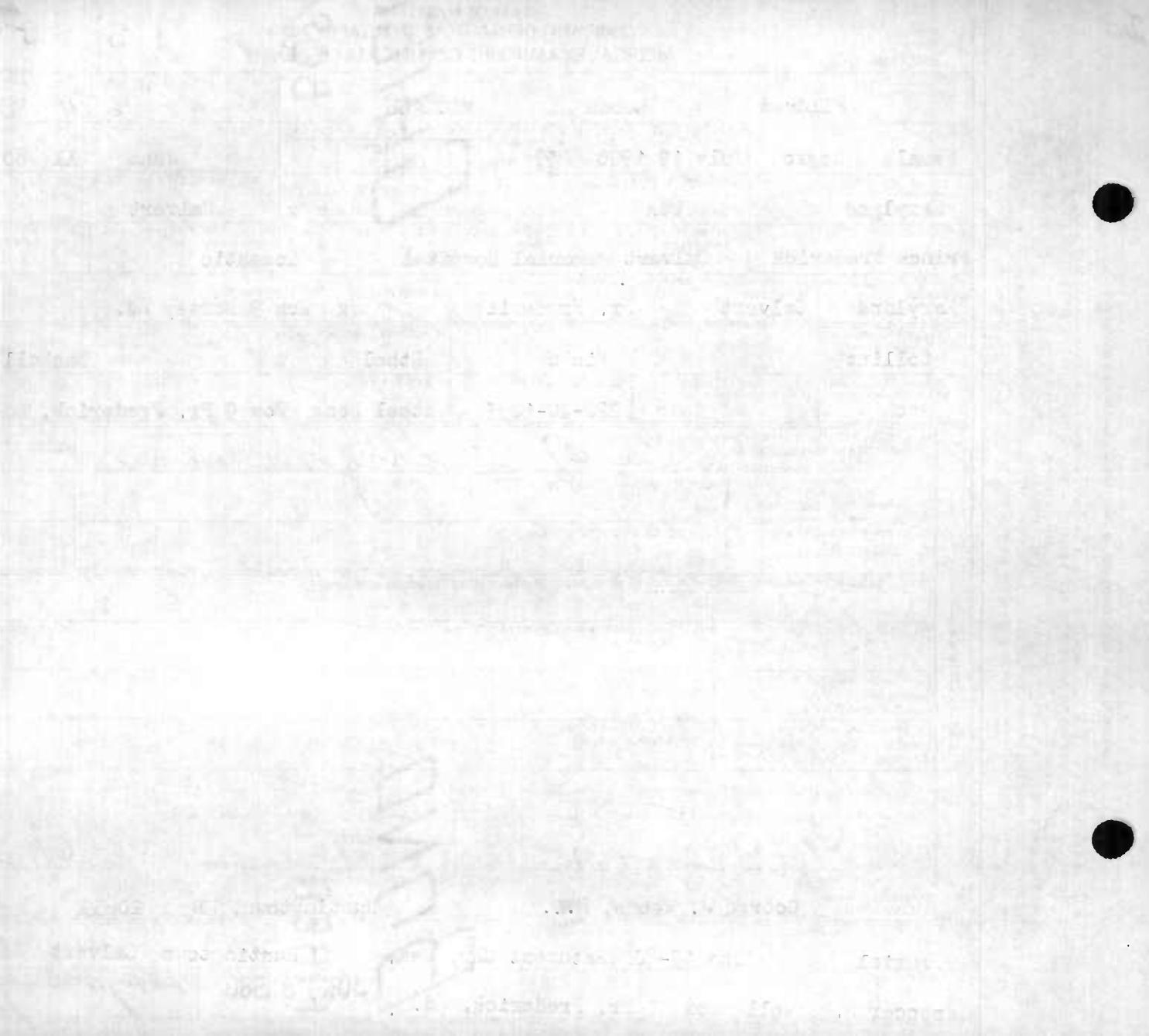
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	0	1	5	4	6	3				
										REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST Ruth			MIDDLE Viola			LAST KEPPLER			20. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 2:55 PM					
3. SEX FEMALE			4. RACE CAUCASIAN			5. DATE OF BIRTH MONTH OCT			DAY 22			6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS			IF UNDER 1 YEAR MONTHS 0			IF UNDER 24 HRS HOURS 255		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? US			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert MD.											
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESPERSON			12b. KIND OF BUSINESS OR INDUSTRY DART DRUG											
13a. STATE MD.			13b. COUNTY CALVERT			13c. CITY OR TOWN LUSBY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS ROUTE 4								
14. FATHER'S NAME FIRST HARRY			MIDDLE -----			LAST DORSEY			15. MOTHER'S MAIDEN NAME FIRST RUTH			MIDDLE -----			16. STREET ADDRESS BOX 334 LUSBY, MD. 20657					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. -----			17. INFORMANT RUTH WHITNEY			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 1a) <u>Metastatic Adenocarcinoma</u>																				
19. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause, if any.																				
(b) _____																				
(c) _____																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (we) attended the deceased from <u>January 19 80</u> to <u>June 4 19 80</u> , that (I) (we) lost saw the deceased alive on <u>June 4 19 80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE <u>Elizabeth Anne Spitzer MD</u>										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>6-5-80</u>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Elizabeth Anne Spitzer, M.D.			22f. ADDRESS South County Health Plan Executive Plaza Prince Frederick, Maryland 20678																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 6/6/80			23c. NAME OF CEMETERY OR CREMATORIAL METROPOLITAN CREMATORIAL			23d. LOCATION CITY OR TOWN ALEXANDRIA			COUNTY		STATE						
24. FUNERAL DIRECTOR DONALD V. BORGWARDT			ADDRESS PORT REPUBLIC, MD.			25a. DATE REC'D. BY REGISTRAR JUN 10 1980			25b. REGISTRAR'S SIGNATURE <u>Donald V. Borgwardt</u>											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH LOCAL CLERKS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 15464				
1- FOR STATE REGISTRAR			2a. DATE KNOWN OF ESTI. DEATH MONTH DAY YEAR									2b. HOUR MONTH DAY YEAR				
1. DECEASED NAME (TYPE OR PRINT) Mildred			FIRST MIDDLE			LAST			<input checked="" type="checkbox"/> 6 11 1980			6 P.M.				
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR July 19 1920		6. AGE (IN YEARS LAST BIRTHDAY) 59 yrs.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR June 11 1980			2d. HOUR 6:28 P.M.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert				
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic			12b. KIND OF BUSINESS OR INDUSTRY MD.	
13a. STATE Maryland			13b. COUNTY Calvert		13c. CITY OR TOWN Pr. Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Box 9 Dorsey Rd.						
14. FATHER'S NAME FIRST Collins			MIDDLE			LAST Hicks			15. MOTHER'S M AIDEN NAME FIRST Ethel			MIDDLE LAST Mackall				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 220-20-1035									17. INFORMANT Ethel Long			ADDRESS Box 9 Pr. Frederick, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Ca of lung, Meloane															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>George J. Weems</i>															TITLE (SPECIFY) M.D. <i>and</i> MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) George J. Weems, M.D.															DATE SIGNED <i>6/12</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 13-80			23c. NAME OF CEMETERY OR CREMATORIAL Patuxent Chr. Cem.			23d. LOCATION CITY OR TOWN Huntingtown			COUNTY Calvert	STATE Md.			
24. FUNERAL DIRECTOR NAME Spencer E. Sewell			ADDRESS Box 31 Pr. Frederick, Md.			25a. DATE REC'D. BY REGISTRAR JUN 18 1980			25b. FEE RECEIVED <i>Spencer E. Sewell</i>							
BP			DHMH - 17 (VR A15 ME (5)) 15M 7/76													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 15465							
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED		MONTH	DAY	YEAR	2b. HOUR
		ERVIN			WADE			SHEETS						<input checked="" type="checkbox"/>		6	27	80	19
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR
male		white		July 1, 1941			38 yrs.			MONTHS		DAYS		HOURS		MIN		7:40:15	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
W. Virginia														Calvert County			MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Calver MEMORIAL Hosp.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Truck Driver			12b. KIND OF BUSINESS OR INDUSTRY					
Prince Frederick																	-		
13a. STATE Va.		13c. CITY OR TOWN Albermarle			Scotsville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			Rt. #3 - H-19B2						
14. FATHER'S NAME FIRST Wilbern		MIDDLE Clayton			LAST Sheets Sr.			15. MOTHER'S MAIDEN NAME FIRST Rosa		MIDDLE Beile			LAST Carrico						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. INFORMANT			16d. ADDRESS			16e. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No		- - -			577-56-6293			Ervin Wade Jr.			12513-Rambling Lane, Bowie, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9108 IMMEDIATE CAUSE (a) Drowning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c)												DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20d. AUTOPSY?											
											YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 4:15 PM 6-27-80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject drowned			21d. LOCATION STREET Huntingtown			CITY OR TOWN Calvert Co., Maryland			COUNTY STATE					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) farm pond																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER							
ACTUAL SIGNATURE <i>Margarita A. Korell</i>														DATE SIGNED 6-28-80					
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.			ADDRESS 111 Penn Street														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-30-80			23c. NAME OF CEMETERY OR CREMATORIUM Stafford Mem. Park			23d. LOCATION CITY OR TOWN Dumfries			COUNTY Stafford			STATE Va.					
24. FUNERAL DIRECTOR NAME Nalley's F. H. Inc.		ADDRESS			Mt. Rainier, Md.			25a. DATE REC'D. BY REGISTRAR JUL 7 1980			25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 0 1 5 4 6 6				
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			June 2, 1980			8:40 AM	
Clare			Demeritt			Smart										
3. SEX male			4. RACE cauc.			5. DATE OF BIRTH MONTH JUNE DAY 23 YEAR 1930			6. AGE (IN YEARS LAST BIRTHDAY) 49			IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert			MD.				
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) carpenter			12b. KIND OF BUSINESS OR INDUSTRY building							
13a. STATE Md.			13b. COUNTY Calvert			13c. CITY OR TOWN Huntingtown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt 1 Box 100				
14. FATHER'S NAME FIRST x ⁵ Clarence S. Smart			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME Nettie E. Demeritt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. Korean 211 28 0788			16c. ADDRESS			17. INFORMANT Dorothea Smart			same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Extensive Carcinomatosis Pancreas and Liver												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<p>1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b)</p> <p>16. DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 65, to June 2, 19 80, that (I) (we) last saw the deceased alive on May 18, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED June 2, 1980				
22b. SIGNATURE <i>Issam F. el-Damalouji</i>			22d. DEGREE M.D.			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
22f. PHYSICIAN'S NAME (TYPE OR PRINT) Issam F. el-Damalouji, M.D.			22g. ADDRESS Prince Frederick, Maryland 20678													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 5, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Wesly Cemetery			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME Rausch Funeral Home			ADDRESS Owings Maryland						25a. DATE REC'D. BY REGISTRAR JUN 9 1980			25b. REGISTRAR'S SIGNATURE <i>Henry McBrady</i>				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.

TO FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR USE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS (301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201) PRIOR TO BURIAL, CREMATION, OR REMOVAL.

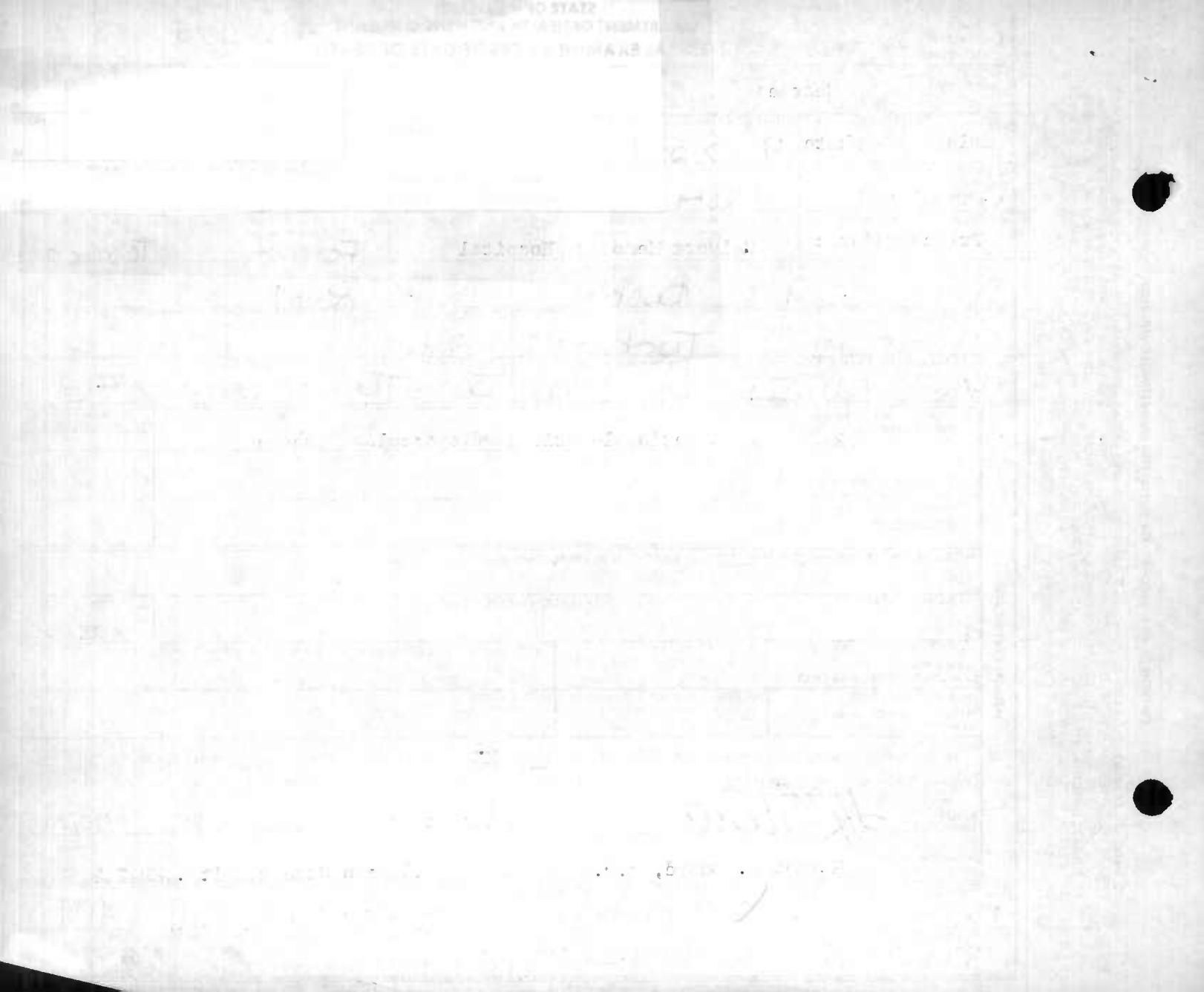
MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15461

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Charles	MIDDLE S	LAST Tucker			2a. DATE KNOWN OF DEATH MATED	MONTH 6	DAY 9	YEAR 19	2b. HOUR 80	
3. SEX male	4 RACE white	5 DATE OF BIRTH MONTH 9 DAY 22 YEAR 57	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 57	7. IF UNDER 1 YR. MONTHS 0	8. IF UNDER 24 HRS. DAYS 0	9. HOURS 0	10. MIN 0	11c. DATE PRONOUNCED DEAD	MONTH 6	DAY 9	YEAR 19	2d. HOUR 1:40	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert County				
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY Tobacco				
13a. STATE Md			13b. COUNTY Cal			13c. CITY OR TOWN Bunkirk			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rural	
14. FATHER'S NAME FIRST Clarence			LAST Tucker			15. MOTHER'S MAIDEN NAME FIRST Estell			MIDDLE Dove				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. 19161472			17. INFORMANT June Tucker			ADDRESS same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>H. Guard</i> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER													
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6-12-80		23c. NAME OF CEMETERY OR CREMATORIAL SOUTHERN MARYLAND GARDENS		23d. LOCATION BUNKIRK, MD		25a. DATE REC'D. BY REGISTRAR JUN 12 1980		25b. REGISTRAR'S SIGNATURE <i>H. Guard</i>			
24. FUNERAL DIRECTOR Kaufman Funeral Home		ADDRESS Owings, MD											

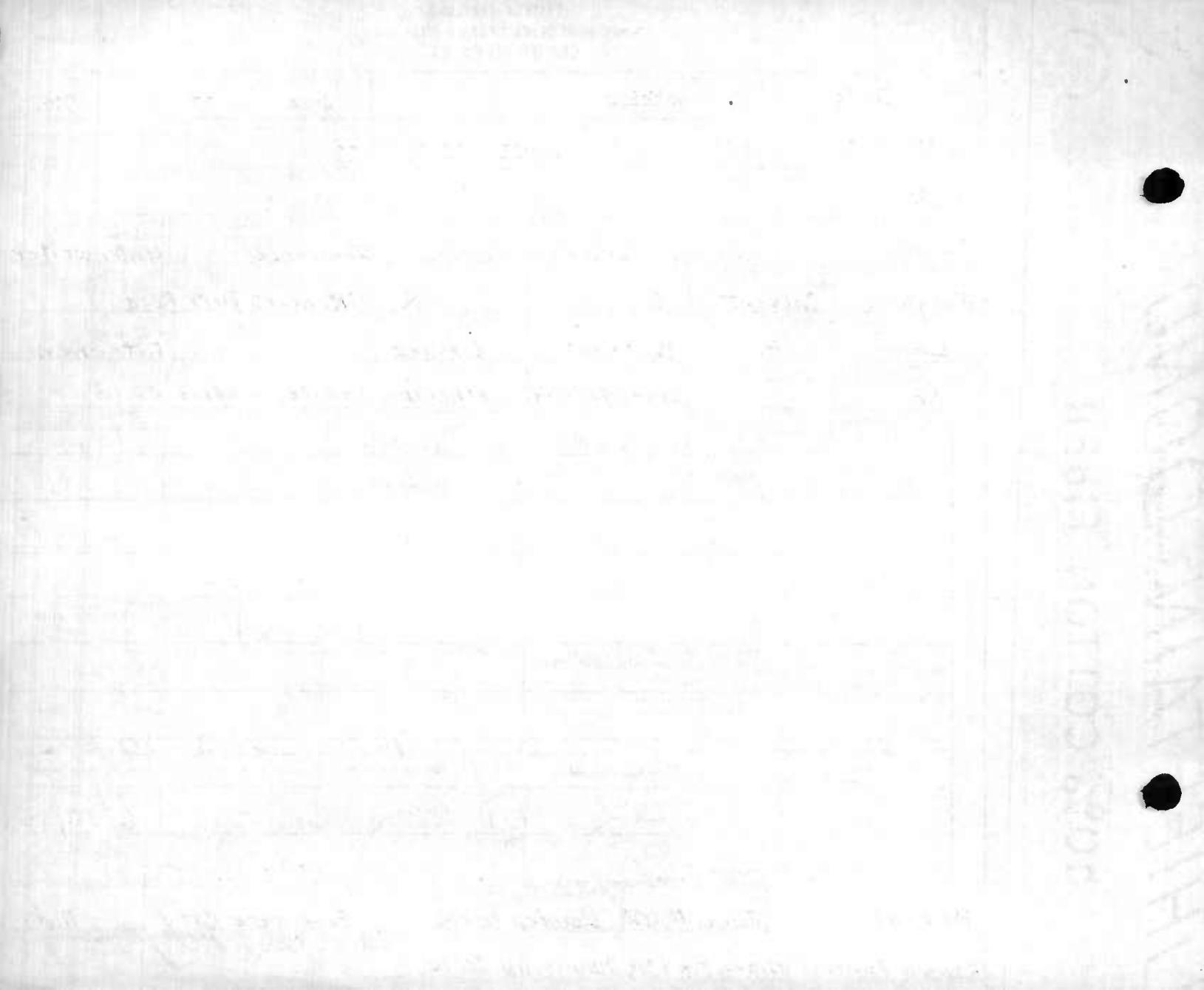


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for us as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 0 15 468	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Lewis F. Watkins									June 13 80			7:45 A.M.	
3. SEX <input checked="" type="checkbox"/> Male		4. RACE White		5. DATE OF BIRTH MONTH April DAY 30 YEAR 07			6. AGE (IN YEARS LAST BIRTHDAY) 73			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Calvert			MD.		
10. CITY OR TOWN OF DEATH Owings			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Skinner's Turn Road, Owings						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance			12b. KIND OF BUSINESS OR INDUSTRY Underwriter	
13a. STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Owings			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Skinner's Turn Road				
14. FATHER'S NAME FIRST Lewis MIDDLE A. LAST Watkins			15. MOTHER'S MAIDEN NAME FIRST Lavina MIDDLE LAST Fitschen			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-07-8589			17. INFORMANT ADDRESS Katherine Lekites - same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min										
1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b), Massive Gastrointestinal Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c), Pancreatic carcinoma/liver metastasis									4 hrs 3 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 cerebrovascular accident / hypertension													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (he/she) attended the deceased from <u>July 26</u> , 1980, to <u>6/13/80</u> , that (I) (he/she) last saw the deceased alive on <u>6/10/80</u> , and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above, (I) (he/she) did (did not) view the body after death.													
22b. SIGNATURE Gerald Stern			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 6/13/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Gerald P. Stern M.D.			22e. ADDRESS P.O. Box 228, Owings Md. 20836										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE June 16, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park			23d. LOCATION CITY OR TOWN Baltimore City			STATE Md.	
24. FUNERAL DIRECTOR NAME Rausch Funeral Home, Box 45A, Owings, Md. 20836			25a. DATE JUN 20 1980			25b. ADDRESS P.O. Box 228, Owings Md. 20836			25c. DATE JUN 20 1980			25d. ADDRESS P.O. Box 228, Owings Md. 20836	



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1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 15469

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE KNOWN OF DEATH ESTIMATED				MONTH	DAY	YEAR	2b. HOUR			
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
10. CITY OR TOWN OF DEATH Prince Frederick			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md			13b. COUNTY Anna Arundel			13c. CITY OR TOWN Crofton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1724 Greenwood place					
14. FATHER'S NAME FIRST Elmer F. Wolfrey sr			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST Naomi		MIDDLE Crawford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT			ADDRESS							
no			213 56 1236			Mary Elizabeth Wolfrey Crofton, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF 8132 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). 19a. DATE OF OPERATION													19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR 7:30PM 6-28-1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET Mochall Rd.			CITY OR TOWN Calvert Co., Maryland	COUNTY	STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													DATE SIGNED 6-29-80			
ACTUAL SIGNATURE <u>Margarita Korell</u> TITLE (SPECIFY) EXAMINER'S NAME (TYPE OR PRINT) MARGARITA A. KORELL, M.D. ADDRESS 111 Penn Street																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE July 2, 1980			23c. NAME OF CEMETERY OR CREMATORIUM Ft Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood			COUNTY Pro Georges	STATE Md.			
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A			ADDRESS Hyattsville, Md.			25a. DATE REG'D BY REGISTRAR JUL 3 1980			25b. REGISTRAR'S SIGNATURE <u>John J. Brady</u>							

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